Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: EDINBURG REGIONAL MEDICAL CENTER 3255 W PIONEER PKWY ARLINGTON TX 76013	MFDR Tracking #: M4-07-2216-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: State Office of Risk Management Box #: 45	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "We have filed an MDR for this service because we believe that the reimbursement received for this treatment was not Fair and Reasonable, as indicated by the commission's implementation of 140% of Medicare rates for physicians and 213.3% of Medicare rates for free standing surgical centers. The Medicare APC rate for this service is $1670.39 times 140% is $2338.55. We only received $1453.40 in payment for this service-seriously below even the APC rate alone. We request carrier to pay 140% of APC rate."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill
3. EOBs
4. Medical Records
5. Total Amount Sought - $885.15

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "**The Office has properly submitted its consistent fair and reasonable methodology pursuant to Rule 133.304(i)(1)(2) for the outpatient services in dispute. However the requestor has failed to present any evidence of its methodology justifying the request for additional reimbursement other than its position of a non-applicable Medicare rate and percentage over that amount. The requestor has further failed to present any evidence that the reimbursement received was not fair and reasonable or ultimately resulted in a loss.** The Office respectfully requests the Division review the provided methodology and deem that a fair and reasonable reimbursement was made for the services in dispute."

Principal Documentation:

1. Response Package
2. Redacted EOBs

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
2/16/2006-2/17/2006	B13, B15, TC, W3, W4, W10, 506	Outpatient Surgery	$885.15	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on November 3, 2006. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after

January 1, 2003, the Division notified the requestor on December 13, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - B13 – Payment for service may have been previously paid
   - B15 – Procedure/Service is not paid separately
   - TC – Technical Component
   - W3 – Additional payment on appeal/reconsideration
   - W4 – No additional payment allowed after review
   - W10 – Payment based on fair & reasonable
   - 506 – Re-evaluated bill, payment adjusted
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §133.307(e)(2)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a copy of each explanation of benefits (EOB)… relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." Review of the documentation submitted by the requestor finds that the request does not include a copy of all EOBs relevant to the fee dispute. The requestor has included two copies of reconsideration EOBs; the EOB with listed audit date 04/18/2006 indicates "Re-evaluated bill, payment adjusted" and "Additional payment on appeal/reconsideration", while the later EOB with listed audit date 08/14/2006 indicates "No additional payment allowed after review." However, the requestor did not submit a copy of the EOB detailing the insurance carrier's initial response to the original bill submission. Nor did the requestor submit convincing evidence of carrier receipt of the provider request for the missing EOB. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(e)(1)(B).
5. Division rule at 28 TAC §133.307(e)(2)(C), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include "a table listing the specific disputed health care and charges in the form, format and manner prescribed by the commission." Review of the *Table of Disputed Services* finds that the requestor has not listed the amounts in dispute in the appropriate column as required by Division instructions. The Division notes that the requestor did indicate that the "Insurance is short $885.15" in the requestor's rationale for increased reimbursement from the *Table*; the Division will deem this amount to be the amount in dispute. However, the Division concludes that the requestor has failed to complete the required sections of the request in the form, format and manner prescribed under Division rule at 28 TAC §133.307(e)(1)(C).
6. Division rule at 28 TAC §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iii).
7. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
8. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "…the reimbursement received for this treatment was not Fair and Reasonable, as indicated by the commission's implementation of 140% of Medicare rates for physicians and 213.3%

of Medicare rates for free standing surgical centers. The Medicare APC rate for this service is $1670.39 times 140% is $2338.55. We only received $1453.40 in payment for this service-seriously below even the APC rate alone. We request carrier to pay 140% of APC rate."

- The requestor did not submit documentation to support the proposed methodology.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The requestor did not submit documentation to support the APC rate or the Medicare payment calculation.
- The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

9. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code sections §133.307(e)(2)(B), §133.307(e)(2)(C), §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

	Grayson Richardson	**4/30/2010**
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.